

111TH CONGRESS
1ST SESSION

H. R. 2948

To amend title IX of the Public Health Service Act to provide for the implementation of best practices in the delivery of health care in the United States, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 18, 2009

Mr. LEVIN (for himself, Mr. HIGGINS, Mr. DOGGETT, Ms. HIRONO, Mr. POMEROY, and Mr. ETHERIDGE) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend title IX of the Public Health Service Act to provide for the implementation of best practices in the delivery of health care in the United States, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Healthcare Improve-
5 ments for Generating High Performance (HIGH Perform-
6 ance) Act of 2009”.

7 **SEC. 2. FINDINGS.**

8 The Congress finds the following:

1 (1) The United States has some of the best
2 doctors and hospitals in the world, but, as a whole,
3 the system is not providing the quality of care it has
4 the potential to deliver.

5 (2) On average, patients receive recommended
6 evidence-based therapies only 55 percent of the time.

7 (3) In the United States, it takes an average of
8 17 years for an established clinical guideline to
9 reach the bedside.

10 (4) More people die from medical errors and
11 hospital-acquired infections in a given year than
12 from AIDS, motor vehicle wrecks, or breast cancer
13 combined. Many of these errors and infections are
14 preventable when best practices are utilized.

15 (5) The United States ranks far behind other
16 countries in many measures of health care quality.

17 (6) The cause of poor quality is not a lack of
18 individual commitment, but a lack of assistance for
19 providers to implement best practices that are proven
20 to work.

21 (7) Experiences in Michigan illustrate the improvement
22 that can be achieved when hospitals and
23 physicians have the tools they need to implement
24 best practices in health care. After Michigan instituted
25 a program to help hospitals implement best

1 practices to prevent hospital-acquired infections in
 2 the intensive care unit (ICU), infections went down
 3 by 66 percent in the first 3 months. After 18
 4 months, Michigan’s ICUs cut infection rates so low
 5 that they outperformed 90 percent of ICUs nation-
 6 wide.

7 (8) In that time, it is estimated that Michigan
 8 hospitals saved \$75,000,000 and over 1,500 lives. If
 9 these results in reducing infections alone were
 10 achieved nationwide, it is estimated that the United
 11 States could save \$13,000,000,000 over 10 years.

12 (9) There is an urgent need to accelerate the
 13 implementation of best practices in health care deliv-
 14 ery to improve the quality and value of health care.

15 **SEC. 3. IMPLEMENTATION OF BEST PRACTICES TO IM-**
 16 **PROVE HEALTH CARE QUALITY.**

17 Title IX of the Public Health Service Act (42 U.S.C.
 18 299 et seq.) is amended by adding at the end the fol-
 19 lowing:

20 **“PART E—IMPLEMENTATION OF BEST**
 21 **PRACTICES TO IMPROVE HEALTH CARE QUALITY**
 22 **“SEC. 941. ESTABLISHMENT OF NATIONAL PRIORITIES AND**
 23 **GOALS.**

24 **“(a) IN GENERAL.—**The Secretary shall establish na-
 25 tional priorities and goals for quality improvement in the

1 delivery of health care services in the United States. In
2 establishing these priorities and goals, the Secretary shall
3 consult with a multistakeholder group convened for the
4 purposes of reviewing available evidence and recom-
5 mending national quality improvement targets. Such
6 group shall include representatives of the various interests
7 and organizations needed to enable change, including con-
8 sumers, physicians, nurses, hospitals and other care deliv-
9 ery organizations, non-Federal purchasers of care, health
10 care oversight or accrediting bodies, research organiza-
11 tions, and entities with successful experience in quality im-
12 provement and quality measurement.

13 “(b) AREAS FOR IMPROVEMENT.—Priorities and
14 goals may be established in at least the following areas
15 recommended by the Institute of Medicine: safety, effec-
16 tiveness, patient-centeredness, timeliness, efficiency, and
17 equity.

18 “(c) PERIODIC UPDATES OF NATIONAL PRIORITIES
19 AND GOALS.—The Secretary shall update the national pri-
20 orities and goals established under this section not less
21 frequently than once every 3 years.

22 “(d) APPLICATION OF NATIONAL PRIORITIES.—The
23 Secretary shall use the national priorities established and
24 updated under this section to coordinate, accelerate, and
25 provide for quality improvement activities and initiatives

1 in the delivery of health care services in the United States,
2 including through the work of the Center for Health Ex-
3 tension established under section 942.

4 “(e) ASSESSMENT OF PROGRESS TOWARD NATIONAL
5 GOALS.—The Secretary shall submit an annual report to
6 the Congress and the public containing an assessment of
7 progress toward the national quality improvement goals.

8 “(f) INTERAGENCY COORDINATION.—The Secretary
9 shall convene an interagency committee, which shall in-
10 clude representatives from the Agency for Healthcare Re-
11 search and Quality, including the Center for Health Ex-
12 tension established under section 942, the National Insti-
13 tutes of Health, the Centers for Disease Control and Pre-
14 vention, the Centers for Medicare and Medicaid Services,
15 the Health Resources and Services Administration, the In-
16 dian Health Service, the Department of Defense, the Vet-
17 erans Health Administration, and other agencies the Sec-
18 retary deems appropriate, for the purpose of coordinating
19 the quality improvement work of such agencies, including
20 the application of the national priorities.

21 **“SEC. 942. ESTABLISHMENT OF THE CENTER FOR HEALTH**
22 **EXTENSION.**

23 “(a) ESTABLISHMENT.—The Secretary shall estab-
24 lish within the Agency for Healthcare Quality and Re-

1 search a Center for Health Extension (hereinafter referred
2 to as the ‘Center’).

3 “(b) DIRECTOR.—The Center shall be headed by a
4 Director who shall oversee the operations of the Center
5 and of the Regional Health Extension Centers established
6 under section 944.

7 **“SEC. 943. MISSION AND FUNCTIONS OF THE CENTER FOR**
8 **HEALTH EXTENSION.**

9 “(a) MISSION.—The mission of the Center is to im-
10 prove health care quality by assisting health care providers
11 to implement and improve upon clinical, managerial, and
12 health care delivery best practices, and to evaluate
13 progress in improving patient outcomes.

14 “(b) FUNCTIONS.—

15 “(1) IDENTIFY AND DEVELOP BEST PRAC-
16 TICES.—The Center shall identify and develop clin-
17 ical, managerial, and health care delivery best prac-
18 tices for implementation in quality improvement ac-
19 tivities.

20 “(2) ASSIST WITH THE IMPLEMENTATION OF
21 BEST PRACTICES.—The Center shall provide vol-
22 untary training and technical assistance to hospitals,
23 other health care facilities, and clinician practices to
24 assist with the implementation of best practices.

1 “(3) MEASURE PATIENT OUTCOMES AND SATIS-
2 FACTION.—The Center shall provide for the meas-
3 urement of patient outcomes and satisfaction, be-
4 fore, during, and after implementation of quality im-
5 provement activities.

6 “(4) EVALUATE EFFECTIVENESS OF ACTIVI-
7 TIES.—The Center shall evaluate the effectiveness of
8 quality improvement activities, and progress improv-
9 ing patient outcomes.

10 “(c) IDENTIFICATION OF BEST PRACTICES.—

11 “(1) IN GENERAL.—The Center shall provide
12 for the identification of highly effective clinical, man-
13 agerial, and health care delivery practices and inno-
14 vations that result in excellent patient outcomes and
15 satisfaction, and can be adapted for use by various
16 health care providers.

17 “(2) SOURCES OF BEST PRACTICES.—The Cen-
18 ter may identify practices and innovations described
19 in paragraph (1) from the following sources.

20 “(A) PROVIDERS AND OTHER HEALTH
21 CARE ENTITIES.—The Center may identify
22 practices and innovations employed by hos-
23 pitals, health care facilities, clinician practices,
24 community cooperatives, and other health care
25 entities.

1 “(B) EMPIRICAL STUDIES.—The Center
2 may identify practices and innovations from a
3 review of relevant empirical studies.

4 “(C) PUBLIC AND PRIVATE ENTITIES.—
5 The Center may identify practices and innova-
6 tions developed by public and private entities in
7 the United States and abroad.

8 “(D) OTHER SOURCES.—The Center may
9 identify practices and innovations from other
10 sources as the Secretary deems appropriate.

11 “(d) DEVELOPMENT OF BEST PRACTICES.—

12 “(1) IN GENERAL.—The Center shall provide
13 for the development of highly effective clinical, man-
14 agerial, and health care delivery practices, taking
15 into account the requirements described in para-
16 graph (2).

17 “(2) REQUIREMENTS.—Practices developed
18 under paragraph (1) shall—

19 “(A) be supported by empirical evidence
20 showing that they have a high likelihood of im-
21 proving patient outcomes and satisfaction;

22 “(B) be specified with sufficient detail of
23 the individual processes, steps, training, skills,
24 and knowledge required for implementation and

1 incorporation into workflow of health care prac-
2 titioners in a variety of settings;

3 “(C) be designed to be readily adapted by
4 health care practitioners;

5 “(D) where applicable, be designed to be
6 consistent with standards adopted by the Sec-
7 retary (under section 3004 of the Public Health
8 Service Act) for health information technology
9 used in the collection and reporting of quality
10 information, including for purposes of the dem-
11 onstration of meaningful use of certified Elec-
12 tronic Medical Record technology by physicians
13 and hospitals under the Medicare program
14 (under sections 1842(o)(2) and 1886(n)(3), re-
15 spectively, of the Social Security Act (42 U.S.C.
16 1395w–4(o)(2), 1395ww(n)(3))); and

17 “(E) where applicable, assist health care
18 practitioners in working with other health care
19 practitioners across the continuum of care and
20 in engaging patients and their families in im-
21 proving the care and patient outcomes.

22 “(3) COLLABORATION WITH HEALTH CARE
23 PROVIDERS AND OTHER ENTITIES.—The Center may
24 collaborate with health care providers and other enti-
25 ties to foster the development of highly effective

1 practices and innovations to improve health care
2 quality.

3 “(4) ATTENTION TO HEALTH CARE DELIVERY
4 DESIGN.—The Center shall specifically provide for
5 the development of best practices for health care de-
6 livery design as described in section 943(g).

7 “(5) ONGOING REVIEW AND IMPROVEMENT.—
8 The Center shall provide for regular review, updat-
9 ing, and improvement of practices developed under
10 this subsection.

11 “(e) TRAINING AND EDUCATION FOR HEALTH CARE
12 PROVIDERS.—

13 “(1) IN GENERAL.—Acting through the Re-
14 gional Health Care Extension Centers established in
15 section 944 (hereinafter referred to as ‘Extension
16 Centers’), the Center shall provide for voluntary
17 training activities for hospitals, other facilities, and
18 clinician practices to assist with the implementation
19 of best practices and innovations identified under
20 subsection (c) or developed under subsection (d)
21 that—

22 “(A) further the priorities established
23 under section 941, once such priorities have
24 been established;

1 “(B) have the greatest impact on patient
2 outcomes and satisfaction; and

3 “(C) are determined to be readily employ-
4 able in health care settings.

5 “(2) TECHNICAL ASSISTANCE.—The Center
6 shall work through the Extension Centers to carry
7 out the following functions:

8 “(A) ESTABLISHMENT OF PARTICIPA-
9 TION.—The Extension Centers shall seek the
10 voluntary participation of hospitals, health fa-
11 cilities, and clinician practices in a region to
12 enter into arrangements to receive assistance in
13 implementing highly effective practices identi-
14 fied under subsection (c) or developed under
15 subsection (d). Hospitals, health facilities, and
16 clinician practices entering into such arrange-
17 ments are hereinafter referred to in this sub-
18 section as ‘collaborating providers’.

19 “(B) ESTABLISHMENT OF COLLABORATIVE
20 TEAM.—The Extension Centers may require
21 collaborating providers to designate a group of
22 members from among the professional and ad-
23 ministrative staff who are responsible for the
24 implementation of the quality improvement ac-
25 tivity or initiative.

1 “(C) ASSESSMENT OF EXISTING PRAC-
2 TICES.—The Extension Centers shall conduct
3 an assessment of the existing practices as com-
4 pared to the identified highly effective practice
5 at each hospital, facility, or practice that par-
6 ticipates in an arrangement under this sub-
7 section.

8 “(D) DEVELOPMENT OF IMPLEMENTATION
9 PLAN.—Each collaborating provider shall work
10 with the Extension Center to develop an imple-
11 mentation plan for the incorporation of the
12 highly effective practice into the care of the
13 provider.

14 “(E) TRAINING FOR COLLABORATING PRO-
15 VIDERS.—Staff of the Extension Center shall
16 work with the collaborating providers to execute
17 the implementation plan. Such staff shall pro-
18 vide instruction and training through electronic
19 media, in-person training sessions, and data
20 analysis to collaborating providers. Such staff
21 shall work with the collaborating providers to
22 carry out this paragraph.

23 “(F) MEASUREMENT OF PROGRESS.—Pur-
24 suant to a data protection agreement entered
25 into between the Extension Center and the col-

1 laborating provider, the Extension Center shall
2 collect data to measure best practice implemen-
3 tation and patient outcomes before, during, and
4 after implementation of quality improvement
5 activities using, to the extent practicable, data
6 already reported for other purposes by collabo-
7 rating providers. Where applicable, the Exten-
8 sion Center shall also collect data to measure
9 the culture of safety.

10 “(G) TIMELY FEEDBACK TO COLLABO-
11 RATING PROVIDERS.—The Extension Center
12 shall provide to each collaborating provider—

13 “(i) analysis conducted by the Exten-
14 sion Center on the collaborating provider’s
15 progress implementing the highly effective
16 practice and improving patient outcomes,
17 and, where applicable, improving the cul-
18 ture of safety.

19 “(ii) information on the collaborating
20 provider’s performance as compared to
21 other like entities participating in similar
22 quality improvement activities, and as
23 available, as compared to other like entities
24 nationally.

1 “(H) CULTURE CHANGE.—The Extension
2 Center may incorporate into instruction and
3 training for collaborating providers activities to
4 improve the culture of safety and foster an
5 ethic of continual improvement among collabo-
6 rating providers.

7 “(I) MEETINGS.—The Extension Center
8 shall provide for meetings of panels of collabo-
9 rating providers working with Extension Cen-
10 ters on similar quality improvement activities
11 for the purpose of reciprocal learning and infor-
12 mation exchange.

13 “(J) COORDINATION WITH OTHER QUAL-
14 ITY IMPROVEMENT ENTITIES.—If an Extension
15 Center is not the organization holding a con-
16 tract under section 1153 of the Social Security
17 Act or a health information technology regional
18 extension center under section 3012(c) of the
19 Public Health Service Act, the Extension Cen-
20 ter shall cooperate with and avoid duplicating
21 the activities of these entities.

22 “(K) OTHER DUTIES.—Such other duties
23 as the Center may specify.

24 “(3) INITIAL QUALITY IMPROVEMENT ACTIVI-
25 TIES.—The Center shall immediately prioritize as-

1 sistance for the implementation of best practices
2 that have been shown to be effective with respect to
3 improvement in the following areas:

4 “(A) HAI.—Health care-associated infec-
5 tions, including reducing catheter-associated
6 urinary tract infection, ventilator-associated
7 pneumonia, and central line-associated blood-
8 stream infections.

9 “(B) SURGERY.—Hospital and outpatient
10 perioperative care, including reducing surgical-
11 site infections and surgical errors such as
12 wrong-site surgery and retained foreign bodies.

13 “(C) ER.—Hospital emergency rooms, in-
14 cluding the development of comprehensive unit-
15 based safety programs, ‘handovers’ of care
16 when transferring patients from the emergency
17 room to other hospital departments or sites for
18 treatment, early identification and treatment
19 for sepsis, and use of principles of efficiency of
20 design and delivery to improve patient flow.

21 “(D) OBSTETRICS.—Obstetrical and neo-
22 natal care, including the appropriate use of ce-
23 sarean sections, and the implementation of best
24 practices for labor and delivery care.

1 “(E) CARE TRANSITIONS.—Transitions of
2 patients between settings, including reduction
3 of unnecessary hospital readmissions and in-
4 creased coordination between teams of unaffili-
5 ated providers.

6 “(f) ASSESSMENT OF EFFECTIVENESS OF QUALITY
7 IMPROVEMENT ACTIVITIES.—

8 “(1) IMPACT STATEMENTS.—Each Extension
9 Center shall make available to the public and the
10 Center impact statements with respect to its activi-
11 ties to assist health care providers to implement best
12 practices. Such impact statements shall contain de-
13 identified information on progress implementing
14 highly effective practices, the impact of the Exten-
15 sion Center’s activities on patient outcomes and sat-
16 isfaction, including lives saved, and cost savings at-
17 tributable to the activities of the Extension Center,
18 and shall include such additional information as the
19 Center may specify.

20 “(2) AGGREGATE IMPACT STATEMENT.—The
21 Center shall aggregate the progress reports of the
22 Extension Centers into a national impact statement.
23 The national impact statement shall contain infor-
24 mation on the aggregate progress implementing
25 highly effective practices, the aggregate impact of

1 the Extension Centers’ activities on patient out-
 2 comes and satisfaction, including lives saved, and
 3 aggregate cost savings attributable to the activities
 4 of the Extension Centers, including cost savings to
 5 Medicare and Medicaid, and shall include such addi-
 6 tional information as the Center may specify.

7 “(3) EVALUATION OF EFFECTIVENESS.—To the
 8 extent practicable, the Center shall evaluate the ef-
 9 fect of implementing individual best practices on im-
 10 proving patient outcomes and satisfaction.

11 “(g) HEALTH CARE DELIVERY DESIGN.—

12 “(1) IN GENERAL.—The Center shall conduct
 13 or fund activities to develop superior designs for the
 14 delivery of health services. This activity may utilize
 15 tools such as operations research, systems engineer-
 16 ing, rapid design laboratories, cognitive and social
 17 psychology studies, materials sciences, and statistics.

18 “(2) EXAMPLES OF ACTIVITIES TO BE CON-
 19 DUCTED.—Health care delivery design activities con-
 20 ducted under this paragraph may examine methods
 21 to—

22 “(A) improve the arrangement of surgical
 23 suites to facilitate teamwork among physicians,
 24 nurses, and other members of the care team;

1 “(B) increase the likelihood that clinical
2 guidelines are followed in care settings;

3 “(C) design medication systems to prevent
4 medication errors;

5 “(D) improve rounding, handoff, and shift
6 changes to improve coordination of patient care;

7 “(E) develop discharge practices that im-
8 prove coordination and reduce confusion and
9 duplicative care;

10 “(F) craft and implement effective patient
11 education procedures; and

12 “(G) improve the design and protocols of
13 emergency rooms to reduce unsafe conditions
14 and ambulance diversions.

15 “(3) SOLICITATION OF INPUT.—The Center
16 shall solicit input from health care providers on
17 areas in which development of best practices in
18 health care delivery are most needed to improve pa-
19 tient care and satisfaction.

20 “(4) REQUIREMENTS.—The health care delivery
21 design improvement activities conducted under this
22 paragraph shall—

23 “(A) be based on identified need for im-
24 provement in a specific area of health care de-
25 livery;

1 “(B) aim to discover or develop designs
2 that can be readily adopted by health care pro-
3 viders and facilities;

4 “(C) aim to improve patient outcomes and
5 satisfaction;

6 “(D) where applicable, be designed to be
7 consistent with standards adopted by the Direc-
8 tor (under section 3004 of the Public Health
9 Service Act) for health information technology
10 used in the collection and reporting of quality
11 information, including for purposes of the dem-
12 onstration of meaningful use of certified Elec-
13 tronic Medical Record technology by physicians
14 and hospitals under the Medicare program
15 (under sections 1842(o)(2) and 1886(n)(3), re-
16 spectively, of the Social Security Act (42 U.S.C.
17 1395w–4(o)(2), 1395ww(n)(3))); and

18 “(E) where applicable, assist health care
19 practitioners in working with other health care
20 practitioners across the continuum of care and
21 in engaging patients and their families in im-
22 proving the care and patient outcomes.

23 “(h) RESEARCH AND RELATED ACTIVITIES.—The
24 Center shall conduct or fund research and other knowl-
25 edge generation activities on the factors that facilitate be-

1 havior change for the sustainable integration of highly ef-
 2 fective and innovative practices into medical practice and
 3 on the factors that foster an environment of continual im-
 4 provement.

5 “(i) PUBLIC DISSEMINATION OF INFORMATION.—
 6 The Center shall provide for the public dissemination of
 7 objective information with respect to activities and re-
 8 search conducted under this Act. Such information shall
 9 be made available through multiple media and appropriate
 10 formats to reflect the varying needs of consumers and di-
 11 verse levels of health literacy.

12 “(j) REPORTS.—

13 “(1) ANNUAL REPORTS.—Not later than April
 14 1 of each year, beginning in 2011, the Director of
 15 the Center shall submit a report to the Secretary on
 16 the activities of the Center and the Extension Cen-
 17 ters during the preceding year.

18 “(2) CONTENT.—Each report submitted under
 19 paragraph (1) shall include information on—

20 “(A) the number of arrangements estab-
 21 lished by Extension Centers with collaborating
 22 providers;

23 “(B) the progress made accelerating the
 24 implementation of best practices by the collabo-
 25 rating providers during the year involved and

1 for such other years as the Director determines
2 to be appropriate;

3 “(C) the level of implementation of best
4 practices at collaborating providers as compared
5 to other providers;

6 “(D) the impact of the work of each Ex-
7 tension Center on patient outcomes and patient
8 safety, including lives saved, and cost savings
9 attributable to the activity or initiatives of the
10 Extension Center;

11 “(E) the aggregate national impact of the
12 work of the Center and Extension Centers on
13 patient outcomes and patient safety, including
14 lives saved, and cost savings attributable to the
15 activity or initiatives of the Extension Centers
16 and the Center, including cost savings to Medi-
17 care and Medicaid;

18 “(F) progress made toward the national
19 goals for health care quality improvement, as
20 established under section 941;

21 “(G) evaluations of the impact of imple-
22 menting individual best practices on patient
23 outcomes and satisfaction, to the extent such
24 analysis is practicable;

1 “(H) research and other related activities
2 conducted or funded by the Center during the
3 year involved and the results of those efforts in
4 improving patient safety and the quality of care
5 in the delivery of health care services or in the
6 science of improvement; and

7 “(I) such other matters as the Center, or
8 the Secretary, determines to be appropriate.

9 “(3) PUBLIC AVAILABILITY.—The Secretary
10 shall transmit each report under this subsection to
11 Congress and shall make each such report available
12 to the public.

13 **“SEC. 944. REGIONAL HEALTH EXTENSION CENTERS.**

14 “(a) ESTABLISHMENT OF REGIONAL HEALTH EX-
15 TENSION CENTERS.—The Center shall establish, either di-
16 rectly or through contracts with qualified entities (as de-
17 fined in subsection (b)), Regional Health Extension Cen-
18 ters (referred to in this Act as ‘Extension Centers’) to
19 carry out the functions described in section 943(e) within
20 such States or regions as the Center determines to be ap-
21 propriate:

22 “(b) DEFINITION.—In this section, the term ‘quali-
23 fied entity’ means an entity that meets all of the following
24 requirements:

1 “(1) DEMONSTRATED EXPERIENCE.—The enti-
2 ty has experience—

3 “(A) in carrying out the type of functions
4 described in section 942(e);

5 “(B) in operating programs on a statewide,
6 regionwide, or nationwide basis to improve pa-
7 tient safety and the quality of health care deliv-
8 ered in health care settings; and

9 “(C) in working with a variety of institu-
10 tional health care providers, physicians and
11 other health care practitioners.

12 “(2) NONPROFIT ORGANIZATION.—The entity is
13 a nonprofit entity organized for charitable purposes
14 under section 501(c) of the Internal Revenue Code
15 of 1986.

16 “(3) GOVERNANCE.—The entity is governed by
17 a board that includes representatives of multiple
18 health care and nonhealth care stakeholders (includ-
19 ing consumers), such that representatives of no sin-
20 gle stakeholder group constitute a majority.

21 “(4) ENTITIES WITH OTHER EXISTING CON-
22 TRACTS.—The performance of services under this
23 act shall be deemed not to create a conflict of inter-
24 est under other existing Federal contracts for qual-

1 ity improvement, health information technology tech-
2 nical assistance, or data aggregation.

3 “(5) AUDITS.—The Extension Centers shall be
4 subject to periodic audit.

5 **“SEC. 945. FUNDING.**

6 “For the purpose of carrying out this part, there is
7 authorized to be appropriated \$200,000,000 for each of
8 the fiscal years 2010 through 2014.”.

○